HEALTH CARE REIMBURSEMENT CLAIM FORM

Part 1: Employee Information:

Employee Name: (First) _____ (Last) _____

Social Security Number: _____-_____-_____ Work Phone: _____

Employer Name: City of Torrance E-mail: _____

Part 2: Address Change Section: (Only complete this section if you have had a change in address.)

Address _____, _____, _____, _____

Part 3: Employee Certification for Reimbursement:

To the best of my knowledge the information listed is true and correct. I certify that the expenses were incurred by me (and/or my spouse and/or eligible dependents). I certify that the expenses listed below are for medical care, excluding cosmetic expenses and items specifically for my general health and understand that upon request additional information may be required from the provider to show medical necessity. I further understand that to be reimbursable the supporting documentation must contain the date of service, the amount billed, and the type of service. Credit card receipts and cancelled checks are not acceptable documentation. I understand that the items reimbursed may not be reimbursed from another type of plan and I will not use the expense reimbursed through this account as deductions or credits when filing my (our) income tax return. I further understand that the expense must be incurred during my coverage period.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature _____ Date _____

Part 4: Itemized List of Expenses:

Service Date (Date Service Incurred)	Amount Requested	Service Date (Date Service Incurred)	Amount Requested
1. _____	$_____	5. _____	$_____
2. _____	$_____	6. _____	$_____
3. _____	$_____	7. _____	$_____
4. _____	$_____	8. _____	$_____

Total Requested $_____ (Minimum Claim Amount $25.00)

Attach and submit **copies** of all supporting documentation for the items listed above. Incomplete forms will be denied for additional information. Account information and verification of claim receipt is available at www.myrsc.com. Please allow 24 to 48 hours after faxing to verify receipt. Customer Service is available 8:00 a.m. to 5:00 p.m., Eastern Standard Time toll free at 800-877-6630. **To set up direct deposit (if applicable) attach a voided check with your first claim.**

FOR QUICKEST REIMBURSEMENT FAX TO 513-326-8082 OR EMAIL 125@SHEAKLEY.COM

Or mail to: Sheakley Flexible Benefits
One Sheakley Way
Cincinnati, OH 45246